

A STUDY OF HYSTERICAL INSANITY WITH AN
ESPECIAL CONSIDERATION OF GANSER'S
SYMPTOM-COMPLEX—REPORT OF
EIGHT CASES¹

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Hysteria is to-day generally regarded as a mental disease. Charcot has described it as a moral malady, and declares that hysterics are such because they are degenerates. As is well known, the French school describes delirium as one phase of an attack of major hysteria.

Many mental symptoms are described as hysterical manifestations such as mutism, lethargy, anorexia, somnambulism, screaming, laughing, sobbing and amnesia. Loss of emotional control and whimsical, vagarious or paradoxical conduct are common expressions of hysteria. Yet hysteria is not ordinarily considered as a form of insanity. But in a certain number of cases the mental symptoms are so exaggerated or profound or so prolonged as to constitute a veritable psychosis. The dividing line must be an arbitrary one, dependent largely upon the point of view and personal equation of the observer. This can be readily understood when we consider that the term insanity conveys no very definite idea and that various observers demand more or less in the number, character and duration of mental symptoms to constitute it. From a psychological point of view it will be generally conceded that the mechanism of hysteria and that of many of the insanities are often, if not always, identical.

Reasoning from the foregoing premises it would seem on *a priori* grounds that a certain number of cases of so-called insanity would be found to be cases of hysteria. But as a matter of fact

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the diagnosis of hysteria or hysterical insanity figures but rarely in the statistics of the hospitals for the insane. It would appear, as suggested by Janet, that when the mental symptoms of hysteria become profound or prolonged and completely dominate the clinical picture, that such cases are no longer designated as hysteria but as insanity. Very often the true character of these cases is not recognized because they are not seen by one observer during their entire clinical course. The asylum physician deals with insanity; and cases coming to him are classified by him under one of the well-known groups of insanity recognized by him. Again, there is a considerable group of observers who recognize hysterical symptoms in various psychoses commonly enough, and who look upon them as complicating features in these psychoses but who do not see in them sufficient evidence to label the psychosis as fundamentally or essentially hysterical in character.

Many difficulties and uncertainties surround the whole subject which is one of not only scientific but also of very practical interest, since the prognosis and treatment are both influenced by the proper recognition of hysterical insanity.

Renewed interest in the subject of hysterical insanity has been created in recent years, largely due to a paper published by Ganser in 1895, in which he called attention to two mental manifestations—*Vorbeireden* and *Dämmerzustand*—which he believed were significant expressions indicative of hysterical insanity. Nearly all recent writers have discussed Ganser's symptom-complex; and it therefore seems to us best to review at the outset some of this discussion.

What has come to be known as Ganser's symptom-complex is characterized by *Vorbeireden* and *Dämmerzustand*. By *Vorbeireden* we understand replies to simple questions which, so to speak, miss the mark, answers which are apparently foolish, silly and inconsequential, and which may create the impression that they were made deliberately in a spirit of fun or were purposely incorrect as by one who is simulating an ignorance of the true replies. The answers bear a certain close relation to the questions and are not merely irrelevant; and the word *Vorbeireden* is probably best translated as "approximate." By *Dämmerzustand* we understand a state of consciousness characterized by mental clouding—a dream-like or veiled state of consciousness which is something different from apathy or stupor.

Vorbeireden as a characteristic of hysterical insanity was first described by Moeli of Berlin. Later Ganser investigated it, and it came to be known as Ganser's sign; while Vorbeireden, together with a Dämmerzustand, became known as Ganser's symptom-complex; and it is regarded by him as a stigma of hysteria.

Raecke, of Frankfort-on-the-Main, who has devoted much attention to the subject of hysterical insanity, states that of the cases admitted to the Frankfort Asylum during the last six years, four to six per cent. were cases of this character. From a study of 186 cases he came to the following conclusions:

The hysterical psychoses are distinguished by their origin and by hallucinations and delusions of a peculiar character; by fleeting ideas of grandeur; by marked variations in the emotional expressions characteristic of hysteria; by hallucinations of an ecstatic character and disturbances of consciousness peculiar to hysteria; by hallucinations and illusions with a strong emotional coloring. The simplest form of the mental expression is the hysterical Dämmerzustand. He recognizes a depressive and paranoic form. As important points he mentions the presence of hysterical stigmata, the extraordinary changes in the clinical picture, the ready influence of the symptoms by outer circumstances and the superficial character of the disturbances.

Emil Raiman ("Die hysterische Geistesstörung") describes hysterical delirium; and he has seen hysterical Dämmerzustand associated with maniacal, melancholic and stuporous mental states. He also recognizes an hysterical paranoia and a pseudo-dementia.

Raiman, in his splendid monograph based on a detailed study of fifty-five cases, considers the mental disturbances of hysterical attacks, hysterical delusions, hysterical Dämmerzustand, chronic hysterical insanity and hysterical psychoses of various expressions. Among 1,135 cases of insanity in women examined by him at the Vienna Psychiatric Clinic he found 126 cases of hysteria—11.1 per cent.; and among 1,723 men, 38 cases, 2.2 per cent. In other words, 5.7 per cent. of the 2,858 cases of psychoses of both sexes were diagnosed as cases of hysterical insanity. Recovery took place in 64.1 per cent. of Raiman's cases.

As illustrating the marked difference of opinion on the subject, it may be mentioned that Forester at the Heidelberg Clinic reported that 13.8 per cent. of the patients suffered from hysterical psychoses; while his successor discovered only 1.5 per cent.

of the cases as belonging to this group. It is a significant fact, however, that scarcely a writer who has investigated the subject denies in toto the existence of hysterical insanity.

Raecke in another paper divides hysterical insanity into two groups; simple hysterical psychoses and other psychoses presenting hysterical symptoms.

The simple hysterical psychoses show psychic paroxysms which are short in duration and not grave in character. He mentions as free from objections in his consideration hysterical furor and maniacal exaltation. In these psychoses clouding of consciousness, with hallucinations of a delirious character, waking dreams, somnambulism, stupor, lethargy, are observed. The stupor is often accompanied by a state of delirium and by expansive ideas. The patient may think himself an animal or child or an aged person.

Among the mixed forms of hysterical psychoses Raecke mentions especially a paranoid and a maniacal group.

Westphall discusses at length Ganser's observations on the hysterical *Dämmerzustand* and *Vorbeireden* and he reports in his valuable paper four clinical cases, in considerable detail. He regards the observations of Raecke and Ganser valuable as diagnostic criteria in the recognition of hysterical insanity. But he nevertheless believes that some of the cases they have reported as hysterical insanity are really cases of *dementia præcox*. Inconsequential answers, he holds, may be observed not only in hysterical insanity but also in *dementia præcox*, which he attempts to illustrate by the clinical cases which he reports. Two of his four cases he regards as examples of hysterical insanity and the other two as examples of *dementia præcox*. *Vorbeireden* and *Dämmerzustand* were marked features of all four cases. In all these cases there was a peculiar mental confusion and a dream-like state of consciousness. Two of the four cases the author regards as cases of *dementia præcox* chiefly because of the presence of negativism in one and a katatonic state in another.

The Ganser symptom-complex, according to Henneberg, occurs five times as frequently in cases of criminals as in non-criminals. He observes that *dementia præcox* is characterized by many symptoms of a hysterical character. He believes the Ganser symptom-complex is not of especial diagnostic value.

Raecke also observes that hysterical stupor is to be frequently

observed among prisoners; and he reports in his paper five such cases. These cases are generally ushered in by a convulsive seizure. The stupor is readily influenced by the operations in the patient's outer world. The reflexes are increased, and pain sense is absent or diminished. The condition may continue hours, days or months. There is complete amnesia for the attack.

The sensory disturbances do not, in the author's opinion, offer conclusive proof of hysteria, since they may be seen in katatonia and confusional insanity. More significant as diagnostic signs, Raecke observes, are the hysterical character and the presence of convulsions or paralysis. Finally he admits that it may be a question whether a given case is one of hysteria or a combination of hysteria and katatonia.

Muradow also attempts to distinguish pure hysterical psychoses from those presenting hysterical complications.

Nissl argues against the acceptance of hysterical insanity as described by some writers. He states that the Heidelberg material reveals only 1.5 per cent. of hysterical psychoses—all women. But he admits that hysterical manifestations are rather frequent in the various psychoses.

Bihler reports two cases of hysterical insanity of interest because simulation was suspected, since both patients were charged with crimes. One patient was a servant girl who told stupid lies and made false accusations. The author considered her case one of moral degeneration on a hysterical basis. The second patient was a highly educated woman affected with religious fanaticism.

A case of acute hysterical insanity is described by Moravcsik. A nineteen-year old girl, whose mother and sister were hysterical, received, on May 6, a letter from her lover, breaking the engagement to marry her. She immediately felt sharp pains in the region of the heart; and clouding of consciousness soon followed, with restlessness, confused utterances, disorientation, insomnia and refusal of food. Fourteen days later she became quieter, and the next day she recovered consciousness and then rapidly recovered; but she had loss of memory for the events since the reception of the letter.

Examination showed the presence of stigmata of degeneration, tremor of the tongue and hands, exaggerated knee-jerks, concentric contractions of the visual fields, acoustic hyperesthesia and marked dermatography.

Hess reports twelve cases of hysterical insanity (one man and eleven women) among 1,729 insane patients. But he has not seen in any of them the hysterical *Dämmerzustand* described by Ganser and Raecke.

Vorster discusses Ganser's symptom-complex and reports five cases, four of which were in criminals. It was difficult for him to distinguish between katatonia and a hysterical condition. Ganser's symptom-complex was present in all these cases. The presence of hysterical stigmata and the fact that the symptoms were readily influenced by suggestion argued, in the opinion of the author, for hysteria. Vorster points out that *Vorbeireden* and *Dämmerzustand* are also seen in epileptics.

Delacroix and Solager report the case of a woman of fifty with various sensory disturbances and contracted visual fields and several other hysterical manifestations who was brought to the asylum because of hallucinations and persecutory ideas. She gave her age as seventeen and made all sorts of false answers as to herself and family. She thought her father dead and appeared to have the most cloudy ideas as to the past. The authors state that the paranoid group is characterized by the fact that patients are subject to suggestion. The delusions come and go and do not appear to be deeply rooted. The maniacal-stuporous form commonly develops on a basis of imbecility and is difficult to distinguish from adolescent insanity. From simple mania, hysterical mania is distinguished by child-like silliness. The emotional disturbances tend to show periodical fogging of consciousness and hallucinations of a delirious character.

Woodman calls attention to the fact that the text-books' consideration of hysterical insanity is very inadequate and that the diagnosis does not appear in the table published by New York State, notwithstanding the enormous number of admissions.

He reports a large number of cases which he has studied and which he divides into several groups as follows:

"First: A group of ten hysterical women all with definite stigmata, whose psychoses present certain features in common; emotional stress is very prominent as a cause; the patients, though sometimes violently insane, tend either in intervals or at all times to be natural in manner and point of view about ordinary things; the symptoms are of varying intensity; and the events of the more intense periods tend to be forgotten. On the other hand, the

symptoms vary from an active delirium to restless melancholia and to passing or more or less persistent delusional states.

"A second group presents one case of so-called involuntional melancholia of hysterical nature, and other cases of depression which do no more than raise the question of hysteria. These patients apparently have a melancholia of the anxious type often seen in the period of involution, but have had similar and milder attacks in early life and without any tendency to an alternating mania phase.

"Third: Cases resembling dementia præcox and the paranoid psychoses. In our case and in other members of her family the symptom groups are intimately combined.

"In the fourth group are two cases of confused hysterical delirium; in one case with physical stigmata, in the second with mental stigmata only. The first of these cases has developed at the last a systematized paranoid trend.

"Fifth, a case of impulsion and obsessive ideas in an hysteric.

"Sixth, a manic attack which during convalescence showed hysterical traits and which was perhaps hysterical also at the onset.

"Seventh, the hysterical dispositions; cases with only mental signs of hysteria and without such attacks as permit one to make a positive diagnosis. The cases are common and well known, and if not really hysterical are closely allied to the hysterical states."

Janet discusses hysterical delirium at some length. One of the cases reported by him showed the symptom of Ganser in typical form; and in this patient hysterical stigmata were absent. There was a dream-like state of consciousness with confused answers (*Vorbeireden*). Speaking of hysterical delirium, Janet remarks:

"Delirious hystericals have, on the contrary, particularly lively hallucinations of all the senses, and it is in the hysterical delirium and the toxic deliriums that visual hallucinations are the clearest."

He believes hysteria may result in intellectual enfeeblement and that it may be considered sometimes as the forerunner of dementia præcox.

Janet holds that even paranoia may be hysterical in character, and he reports an illustrative case. He also discusses the question which most authors who have considered this subject have also dealt with, namely, the relation of hysterical mental manifestations to other psychoses and also their relation with other phe-

nomena of hysteria. His views may be seen pretty well from the following paragraph:

"A disease is not an immutable entity, easily recognizable. It is a classification of symptoms grouped for the convenience of our mind. Hysteria is but a syndrome, an ensemble of facts grouped in a general idea, which facts are nearly all moral facts; they are somnambulisms, attacks, fixed ideas, disturbances of the attention, forgetfulness, insensibilities, which are psychological phenomena. There is no valid *a priori* reason to refuse to bring within this framework deliriums that are simply other mental phenomena. Besides, these authors themselves scarcely apply their doctrines in their extreme sense, for they accept the delirium of the attack, and even anorexia, which is, to a supreme degree, a delirium of long duration. We may then consider certain deliriums as hysterical."

Bauman reports the case of a patient who, following an accident, had been excited and suffered from many delusions and hallucinations. He scolded everybody and accused his wife; he tore up bedclothes, etc. He was disorientated for time and place. Vorbeireden was observed. This condition lasted ten days. The patient's condition very suddenly and markedly changed for the better. There was total amnesia for the excited period.

The case was at first thought to be one of paretic dementia, and that the accident was due to apoplexy. The Vorbeireden, although recognized as an unusual manifestation in such a condition, was admitted as a possibility. With the sudden improvement of the patient when changed to another institution, and especially on finding hysterical stigmata and amnesia, the diagnosis was changed to that of hysterical insanity.

Bauman's conclusion is that the symptom-complex in a case such as he has reported cannot be ascribed to the negativism of katatonia as held by Nissl.

Soukhanoff in an able paper remarks that since the publication of Ganser's article, a sufficient number of well-followed observations have been recorded to enable us to speak with assurance of Ganser's symptom-complex. He points out that it is due to Ganser that we see in Vorbeireden a symptom and not a species of simulation. Soukhanoff discusses the question as to whether Ganser's symptom-complex constitutes a distinct morbid entity; and he holds that the question is an open one. Since the

symptom appears frequently in persons arrested for crimes and those injured by railroads, it is evident to him that moral shock constitutes a great etiologic factor. Soukhanoff believes that Ganser's symptom-complex must be regarded as an important mental stigma of hysteria; but he admits that it may be seen in other psychoses, and especially in dementia præcox.

In looking for a psychological explanation, the author believes that the Ganser symptom-complex is due chiefly to faulty association of the sensory impressions. He sees an analogy with hysterical palsy and hysterical amnesia, which he would explain in a similar way. This is really much like Janet's explanation of hysteria in general, a failure of synthesis of sensory percepts.

Some weeks ago we had the pleasure of visiting the Sheppard Hospital, near Baltimore, and of examining some of the cases which are regarded by the members of the staff of this hospital as cases of hysterical insanity. The diagnosis is not overlooked in this institution. In writing to one of us a short time ago regarding Ganser's symptom-complex, Dr. Dutton observes that "While frequently confused with the irrelevancy of dementia præcox, it is somewhat different in character and appears to be more purposeful, in that the answers are more absurd and the patient of course shows less demented symptoms. This is in many cases a fine distinction, but I think it has been observed comparatively in a number of cases that we are frequently able to differentiate it."

Moreau de Tours looks upon so-called hysterical insanity as in reality a simple delirium; and he holds that even if hysterical symptoms are occasionally observed they are to be accounted as nothing more than complicating phenomena. Hysteria is often associated with various forms of mental alienation. He does not recognize hysterical insanity as a morbid entity. Attacks of delirium, depression, excitement and even periods of great excitement with distinct delusions and hallucinations are to be regarded as episodes in the life of hysterical individuals—equivalent to ordinary hysterical paroxysms. Hysteria may *simulate* or accompany and complicate various mental affections. Hysterical paranoia, melancholia and mania do not exist. They have no logical basis. He observes that the careful reading of the cases reported as forms of hysterical insanity shows that the course, character, duration of the various symptoms are not those

of the typical psychoses, but that they are of the sort of translation of ordinary hysterical paranoia, and that they may be the result of auto-suggestion. He reports a case of hysteria associated with epilepsy exhibiting mental phenomena of excitability, paradoxical conduct, delusions and hallucinations of short duration and frequent in number, and all developed by auto-suggestion as by reading a love story, etc.

Ruggles has also inquired into the question of Ganser's symptom-complex; and for this purpose he has examined 170 cases of insanity of all kinds. Of these 170 patients, 110 answered questions correctly; 40 answered more than one half the questions correctly; and 17 answered them incorrectly. For various reasons in three cases Vorbeireden was noted; and all these cases are cases of dementia præcox. Upon second and more pressing examination, by asking the same questions, these signs were absent. When the patient was asked why he answered so foolishly in the first examination he said that he gave foolish answers because the questions were foolish. Ruggles believes that the first answers were made deliberately. He thinks it is fair to say that in many cases undue importance is attached to the sign of Vorbeireden as a manifestation of hysterical insanity. He believes that it is not necessarily a significant symptom, but often a matter of suggestion, perversity, obstinacy or carelessness. He believes that at least for dementia præcox this holds good. Although he admits that for hysterics the symptom may have another meaning, he holds this to be improbable when we consider the perversity of these patients.

We have observed Ganser's symptom-complex in only a few of the cases of insanity and in these usually in an incomplete form. But in at least one of our cases, which we regard as one of hysterical insanity, it formed a striking feature of the clinical picture. Dämmerzustand alone has been noted by us much more frequently.

Reviewing the foregoing studies and our own limited observations it would seem that Vorbeireden appears in a variety of different psychoses and that it is by no means characteristic of hysterical insanity. Vorbeireden in association with Dämmerzustand is far more significant of a hysterical psychosis. Yet it is by no means to be regarded as invariably an hysterical expression; for it too is to be seen as an expression of other mental

states. But its presence is to be regarded as suggestive of an hysterical insanity. We look upon it as a mental expression which probably is of considerable value in the recognition of hysterical psychoses. But like other expressions or stigmata of hysteria it can only be of value when considered in connection with other signs or symptoms pointing to hysteria. Probably in the majority of cases of hysterical insanity Ganser's sign is absent in its typical form.

The consideration of Ganser's symptom-complex has led us to study certain delusions which we have observed in the hysterical psychoses which appear to us to be in keeping with the symptom of *Vorbeireden* and which might be designated as foolish, absurd or inconsequential delusions. Most of them relate to the patient's own body and are of the variety known as somato-psychic; and these are probably dependent upon faulty sense perception and faulty synthesis of sensory percepts and really constitute a form of dissociated personality. One patient, for example, complained greatly that she did not have her own hands and feet, that she had no hands or feet and talked of and lamented the circumstance a great deal. Another patient seen by us at the Sheppard Hospital spoke of having three heads and would discuss the matter very glibly and in a most absurd fashion. Another patient complained that she did not possess her own legs, but had her brother's, to which she greatly objected. Another complained that there were snakes in her head, that her body contained much glass. She declared the doctor was a baboon and often saw in her sleep Adam and Eve in the Garden of Eden. Another patient complained that hair was put in her coffee and milk.

These delusions appear as silly, foolish, theatrical, almost as though assumed for effect and appear as comparable to the foolish, silly answers which constitute the *Vorbeireden* of Ganser and are suggestive of the same sort of a psychosis. We look upon them as of considerable significance as indicative of an hysterical psychosis. But like other symptoms they are not sufficient in themselves to warrant this diagnosis; but are of great diagnostic value when taken in connection with other evidence pointing to hysteria.

The diagnosis of hysterical insanity can be made with the greatest certainty when in addition to the mental expressions of

the psychosis one can find certain of the well-known expressions of the great neurosis, such as contracted visual fields, disturbances of sensation, convulsions, aphonia, paralysis, astasia, abasia, contractures, suppression of urine, etc.

Unfortunately in many cases the visual fields and the state of sensation cannot be properly tested by reason of the insanity. But yet it often happens that at some time in the course of the psychosis or upon its subsidence these tests can be made; for we have the records of a considerable number of them.

In considering the evidence offered by a test of sensation we must be cautious in attaching too much significance to the presence of universal analgesia. For this may be found in a variety of psychoses, as, for example, melancholic states, and in dementias of various sorts. But hemianalgesia and segmental analgesia are distinctly significant.

In many cases of hysteria—probably in the majority—sensory disturbances are absent; and this is true of the hysterical psychoses as well as of other forms of hysteria.

In considering then the diagnosis of the hysterical psychoses all evidence pointing to hysteria should be carefully examined and weighed. We shall here, however, confine our discussion to the psychic expressions of the disease.

It would appear then from the evidence at hand that on the mental side hysteria may simulate almost every known physical disease. On the mental side as on the physical the counterfeit is often apparent. But in many cases the question of diagnosis will prove most difficult and in some insurmountable. In some instances the diagnosis can be made with reasonable certainty; while in many more as only probable, and in still others it must remain doubtful.

Probably the most common mental expression after the exaggerated hysterical character is that of delirium. But maniacal, melancholic and perhaps even paranoid symptoms are to be seen. Peevishness, querulousness, fault-finding, exaggerations, dramatic conduct indicative of the hysterical character are common enough. The Ganser symptom-complex and the foolish delusions already referred to may be encountered. As in the case of other symptoms, the mental phenomena may be paradoxical in character, exaggerated and theatrical in expression. Then too great suddenness in the change of the symptoms may be observed

and the fact that they are influenced by suggestion. Oftentimes the psychosis exhibits several contradictory expressions and the impression is created in the mind of the observer that it is different from and fails to tally with those of the insanities he has adopted for his own classification. The disease may express itself chiefly by the hysterical character. Finally the course and the mode of the termination of the psychosis is of diagnostic significance. We may here remark that the four cases of hysterical delirium previously reported by one of us (Dr. Diller) all terminated in recovery; and none has relapsed or exhibited residual dementia, a point which emphasizes the correctness of the diagnosis, since three years have now elapsed since that report was made.

Probably the greatest difficulties arise in differentiating hysterical psychoses from delirious and maniacal states and from dementia præcox. We shall say a word regarding dementia præcox only. Its negativism, mannerisms, mutism, impulsive conduct and katatonic stupor are each in turn suggestive of hysteria. We have encountered several cases in which we were unable to make differential diagnosis between dementia præcox and hysterical insanity. We can here only offer the suggestion that in some instances the diagnosis can be cleared up by prolonged observation. Negativism is not conclusive evidence of dementia præcox; for hysterical mutism is a marked species of negativism.

The question of the differential diagnosis is one of practical importance and especially in those cases in which it is a question as to whether the patient suffers from dementia præcox or hysterical insanity. The question is not one of mere academic interest, for if a given case can be recognized as one of hysterical psychosis, the prognosis is far better than if it be one of dementia præcox.

Hysteria of any sort may, however, prove to be chronic or may show frequent relapses; and the hysterical psychoses conform to this rule. Two of the cases we have to report were examples of recurrent hysterical psychosis, each of which ran a course covering many years.

With this brief discussion we shall now offer for consideration several clinical records to illustrate some of the various points which have been discussed. We feel the inadequacy of this

discussion, but we are impressed with the importance of the subject of hysterical insanity, and we feel that it deserves and should receive far greater attention and investigation on the part of neurologists than it has hitherto received, for the subject is one full of interest whether viewed from the scientific or practical point of view. The material is abundantly at hand and only awaits investigation.

ACUTE CASES

CASE I. Mrs. X., married, age 26, of Pittsburg, first came under the care of Dr. Wright, in June, 1906. In the family history we find one uncle epileptic, and a brother alcoholic; and the previous personal history is without especial note except for the appearance of a simple goiter at the age of fifteen. The patient has always been willful and stubborn and has been much humored by her family. At the age of nineteen, much against the wishes of the entire family, she married a man of a different religion. This marriage turned out unhappy. The husband was a periodical drinker and sometimes would go away for a week at a time and nothing be heard of him.

The present sickness began in June, 1906, after three months of vague neurasthenic symptoms much augmented by family troubles and the fact that the patient found herself pregnant. At the second month of gestation she induced an abortion, at which time Dr. Wright was called. The ordinary treatment was followed and she promptly recovered. The patient, however, was much depressed by her deed and suffered acute remorse. She became restless, sleepless and talked much of her sin. She saw thousands of babies pointing their fingers at her. Later she saw fiery devils. She was very emotional and cried a great deal. She became very childish and unreasonable. She cried for a \$1,000 check, then for a silver purse, then for a special variety of toilet water. When her requests were not granted she would have noisy, violent spells, by which she was completely exhausted.

About the first of July the patient was removed to the Allegheny General Hospital. Here the silly emotional paradoxical conduct continued. One day she worked herself up in a very violent spell because she could not have her nails manicured by a particular manicurist. She became more and more childish in her actions—imitating a child in speech. She spoke of her brother-in-law as "uncle-doctor." She begged to have her hair cut short, and even attempted to pull it out. Sitting in bed with a bottle of toilet water under one arm, a silver picture frame under the other, and a silver purse dangling from one wrist, she presented a comical picture. Attempts to take away these articles resulted in producing a condition of semi-delirium. The

patient slept little. She refused to eat and had to be restrained in bed. Examination at this time revealed almost complete hemi-analgesia on the right side. The knee-jerks were somewhat exaggerated.

The patient grew rapidly worse and finally sank into a state of active hallucinatory delirium. The tongue became dry and coated; the pulse rapid and somewhat weak. Dr. Diller was called in and pronounced the case one of hysterical delirium.

After being in the hospital about a week the patient began suddenly to improve. She slept better, ate better and became more and more tractable. She took an interest in her surroundings and was soon able to walk about. In about three weeks after admission she seemed well enough to leave and she was sent to the country, where her sister had a large place, to recuperate. On leaving the hospital she was quite weak; she had lost much flesh. Mentally, except for capriciousness and selfishness, she seemed almost herself again. There was amnesia for most of the events which had occurred in the hospital.

In the country the patient did quite well for a time; she gained in strength and weight and was able to take long drives. There was some difficulty in securing sleep, and backache was complained of most bitterly. About the first of September, when the patient seemed about ready to come home, some family trouble occurred, and an effort was made to separate the patient from her husband. Of course she was much excited by all this. She came home and a very painful scene occurred. Almost at once there was a recurrence of the old trouble. The patient became utterly unmanageable and frequent threats of suicide were made. At this time it was noticed that the patient was lame, absurdly so. She walked as if one leg were at least four inches shorter than the other, and she used a cane. On examination there could be found no cause of this or for the backache so bitterly complained of.

About the first of September the patient was placed in the care of Dr. Diller at the St. Francis Hospital. Here, for the first ten days, she became much worse. She was excited and had hallucinations. She saw devils, babies, etc., she was sleepless, ate nothing, and when tubed tore the tube to pieces. She took an intense dislike to Dr. Diller and used the most insulting personal abuse. Finally she became delirious and her tongue coated and dry. Her pulse was weak. Urine and feces were passed involuntarily. It seemed as if she would die. Three days later, however, she began to improve in every way, and continued to do so rapidly. She became quiet, slept fairly well and began to eat. She treated Dr. Diller respectfully; in fact she seemed to have almost a fear of him. In about ten days after admission she was almost her own self and wanted to go home. At the end of three weeks she was almost well. The lameness

had entirely disappeared. There was almost entire amnesia for the events of the first week, but good memory for those of the latter two weeks.

The patient was now sent to a sanatorium in New Jersey to recuperate, and after three weeks returned entirely well. Since then she has gained steadily in weight. She has been able in the past year to experience the death of her father, her brother, and one of her own children within a period of six months, without any unusual emotional reaction. In August of last year she gave birth to a ten-pound baby. At the present time is sound and healthy in every respect.

Comments.—This case appears to us as a clear one of hysteria. Besides the very evident hysterical conduct and delirium, the hemianalgesia and lameness strongly argue for hysteria. A point of considerable interest in this case is the great disturbance of metabolism, as evidenced by dry tongue and which was noted at one stage of the attack; and the fact that at this time the exhaustion and toxemia were so pronounced as to threaten apparently the life of the patient.

CASE II. (Dr. Diller.) The next case is one which presents some indications of melancholia; and the account which I received from the friends before I had seen the patient led me to expect that I would see a patient with melancholic depression.

I was told that for six months past the patient had been mentally unbalanced; that she was depressed and that she thought her soul lost and had often threatened to kill herself, and had made two or three attempts to do so, once with a towel, another time with a knife. She believed that her family were conspiring to get her out of the house in order to break up housekeeping; thus she would be thrown out of a home.

The patient was a single woman, thirty years of age. She had been ailing more or less for a couple of years. She has organic valvular disease of the heart. She had acted as housekeeper for her brothers and sisters in a small country village and had seldom been from home. It is said there is no insanity in the family.

With this account, I visited the patient at St. Francis Hospital, where she was brought February 26, 1908. I found her sobbing a great deal and calling out to the sister that she wanted a private room and did not want to be in a ward with other patients. The sobbing and protestations were of an exaggerated character. It at once struck me as very odd that a melancholic patient should be so particular as to her surroundings. I said to her in a sharp tone that she was carrying on in a foolish way and that she should quiet herself and behave sensibly. She quieted down in a few moments. Then looking at her, smiling, I said, "Now cheer up! Smile a little! See Rosy smiling at you!" (the old nurse). Almost at once a smile lighted up her

face and this was quickly followed by an extremely loud outburst of diabolic laughter, which kept up for about a minute, during which time the patient's face was very red and congested. Tears had now entirely disappeared.

I saw the patient half an hour later. She was now in bed, quiet and composed. She asked me why she was brought here. She knew quite well that she was in a hospital, and that the patients about her were insane. She protested that she did not need to be here. After a short conversation, she was seized with another laughing fit, not so loud as the first one. She sprang from the bed with arms extended towards me, offering to embrace and kiss me.

I subsequently learned from her sister and her physician that she had been in bed three months past and that many of her friends came to see her. Often at these visits she would break into loud laughter and stretch out her arms to embrace and kiss these friends, whether of the male or female sex, just as she had done to me.

A physical examination revealed a mitral-regurgitant murmur. The general appearance of the patient, however, was good. She was well nourished. On test with pinprick she appeared to have universal hyperesthesia.

The day after admission, the patient had a loud screaming spell which lasted continuously for three hours, and which was terminated by immersion in a cold bath. After this no screaming attack occurred. The patient cried from time to time. Her conduct in the main was peevish, irritable, fretful; but she did not reveal any definite delusions or hallucinations. She soon began to ask to go home in a fretful, peevish way, much after the manner of a spoilt child.

She left the hospital about six weeks after admission much improved.

Comments.—The sudden emotional displays of this patient, with her dramatic, whimsical, peevish, paradoxical conduct are so indicative of the hysterical character, and the marked influence of suggestion seem to us to clearly indicate the hysterical nature of this case. On the negative side it presents no resemblance to any other of the well-known insanities.

CASE III. (Dr. Diller.) The next case is that of an unmarried woman, 34 years of age. Her family and previous history are both negative. The patient was brought to St. Francis Hospital, January 10, 1908. She had been mentally unbalanced for about three months previously. From the account given by her brother and physician, I learned she had been working steadily for many years as housekeeper for her brothers and sisters. She had been very faithful to her duties and had scarcely ever been away from home.

Previous to coming to the hospital she was noisy, mischiev-

ous, whimsical, devilish, fretful, all by turns. She had been ill about two months. She had been in a general hospital in the neighborhood. Here by clever dodges she had escaped the surveillance of her nurses and gone home several times. On several occasions she had screaming attacks and on one occasion she danced on the top of the piano. For several weeks before coming to the hospital she had conceived the idea that her hands and feet were missing; at other times she would say that she could not feel her hands or feet; again that if she had hands and feet they were not her own, but belonged to some one else. On admission to the hospital she was lamenting a good deal about her hands, and her brother assured me that this was the only evidence of insanity. She appeared depressed and worried and fretted a great deal about her hands, to which she made constant reference.

The patient seemed well nourished. Physical examination revealed nothing especially significant. Skin sensations appear normal; knee jerks exaggerated. When the hands are pricked with a pin she quickly withdraws them, saying this is painful.

During the next three weeks the patient fretted and fussed a good deal about her hands and her general condition and the "awful state" in which she was in. Her complaints were of a peevish, fretful character. Her memory appeared good and her face and general conduct indicated intelligence. She was well orientated, for both time and place.

January 28 (fourteen days after admission), after a "queer feeling," she fell to the floor in what the sister thought a sort of faint. I found her in bed on the afternoon of that day. She was now complaining bitterly. She said she would never get out of bed and that she would never do any good. But she did soon get out of bed and began to improve, and the improvement was rapid. She often asked to go home. She was always told that when she would behave quietly and sensibly, and stop the foolish talk of her hands, etc., she would be allowed to go home. A strong effort was made to impress her with the fact that she could control herself if she would only set out to do so and that the ideas of her hands are foolish vagaries which she had allowed herself to entertain.

I am quite confident that the suggestion operated strongly in restoring the patient to health. She left the hospital after a stay of about two months, apparently restored to health.

Comments.—Here again we have a psychosis which does not conform to that of any of the well-known psychoses. The diagnosis of hysteria rests chiefly upon the hysterical character of the patient, her changeable, fretful, whimsical, paradoxical conduct and her apparently foolish, silly somato-psychic delusions regarding her hands. It is this sort of delusion which appears to us as very like the foolish, silly answers to which Ganser has directed attention.

CASE IV. A single woman, aged 34, was admitted to the St. Francis Hospital, October 11, 1907. She is the mother of a child six years old. Her mother was an inmate of an insane asylum.

She had been insane for several weeks before admission. She thought she was robbed in the house at night where she heard noises. She thinks people are talking about her. The walls and ceiling get black. She sees objects on the floor. She believes she is being "doped" and that people are giving her chloroform. She has periods of depression.

On admission she was very stuporous for about a week and then she became noisy. She was extremely agitated and noisy for a period of four or five weeks. During this period her tongue became dry. She had to be fed by the stomach tube for a period of two months.

December 7. To-day she is quiet and placid. She eats when fed with spoon. She sometimes soils herself.

December 21. The patient feeds herself without assistance. She is quiet most of the time, but appears to have dream-like consciousness. She says nothing and replies to questions only occasionally. She keeps her eyes persistently closed and resists efforts to open them. Occasionally she becomes loud and noisy, or sings, or has spells of loquaciousness. Her replies to questions are much more sensible sometimes than at others. At times the answers are so beside the mark as to suggest *Vorbeireden* of Ganser. She may repeat a few words of the end of a phrase. To-day for the first time she lies in an uncomfortable position, her head resting on an iron bar at the top of the bed. She makes pantomime motions. The tongue is now comparatively clean and the patient reacts promptly to pin pricks. Her physical condition is fair.

December 28. The patient is improving. She is quieter and more tractable. She attends to the calls of nature.

January 6, 1908. She has been up out of bed and dressed during the last week. She is steadily improving.

February 8. She talks better; but much that she says is disconnected. She speaks in an indefinite way of someone being killed.

February 15. The confusion and loquaciousness previously noted have cleared up. She looks quite well and talks connectedly. She has just written a sensible letter to one of her relatives. Her memory for events of her illness seems very cloudy.

February 22. Pain sense is greatly diminished, especially over arms and legs. The patient now talks quite rationally, and she has been rendering very efficient work in the wards. She asks in a sensible way to go home.

A couple of weeks later the patient was discharged apparently restored to health.

Comments.—This is one of the cases in which we have made a diagnosis of hysterical insanity with some reserve. There are

several features which point to this diagnosis, namely, the sudden change in the mental state; the great variety of mental expressions and silly delusions and answers to questions; the state of cloudy consciousness; the amnesia; the analgesia; the development and the course of the case. On the negative side, the case does not fit in very well under any of the heads named in the classification of Kraepelin.

CASE V. An Irish woman, aged 30; married. She was admitted to the St. Francis Hospital January 30, 1908. Her family history was negative. She herself had always been strong and healthy. She had been in this country only a short time.

The beginning of her present illness dates back to four weeks ago, when her husband died. For three days following his death she seemed bewildered and dumbfounded. For a period of two days she refused to eat. She believed that hair was in the food. Afterward she became noisy and continued so night and day for several days.

On admission the patient was very loquacious, agitated and untidy. She made many nonsensical statements and often repeated herself. For example, she talked of people putting hair in her medicine and pins in her bed. She makes false statements as to events in the past and gives absurd answers to questions (*Vorbeireden*). Although she talks much her voice is not loud but monotonous and tiresome in tone.

Physical examination revealed nothing especially significant. The patient's general appearance and cranial formation indicate rather low development. She appears to have universal analgesia.

January 31. The patient now appears to be in state of mental depression. She is apathetic and says nothing except in reply to questions. She falls into tears while speaking. She appears to be correctly orientated.

February 11. For several days recently she lay in a stuporous state. To-day she speaks readily.

February 15. Since the last note she had two stuporous attacks each about two hours in duration, when she appeared wholly unconscious of all her surroundings. She wakened out of both these attacks quickly and at once appeared as bright as before.

A significant feature of her case is the fact that during the visit of her brother, one week after admission, she brightened up greatly and talked to him sensibly. After his departure she at once relapsed.

She has been a good deal brighter the last couple of days. To-day she was visited by her late husband's brother from her old home in Ireland; and she and he had a sensible talk over the matter of her return to the old country. Her brother-in-law thought her mental condition about normal. She asked to be allowed to leave for Ireland with her brother-in-law. She accordingly left for Ireland the next day. A letter has since been received from the

brother-in-law stating that he had no difficulty with her whatever crossing the ocean and at home, among her old friends, she seems to be quite herself and in a normal mental condition.

Comments.—The significant features of this case are the onset after a great psychic shock; great variability in mental phenomena, stupor and apathy, alternating with delirium and loquaciousness (*Vorbeireden*), absurd delusions (hair in food) and the marked influence of suggestion upon the patient. There was a most marvelous contrast between this patient's general appearance as she walked out of the hospital on the sixteenth of February and that of only a few days previous in which she lay in apparently katonian stupor which one might have supposed would have meant weeks or months of hospital confinement ahead of her.

CASE VI. (Dr. Diller.) Man, aged 51 years, salesman, jeweler, 28 years married, father of two grown daughters. He smokes a good deal. His wife says he does not drink, but in his delirium the patient spoke of drinking freely and having been under the influence of liquor. I later learned that he drank a good deal. He is a man respected in the community and considered a reliable man and one of good habits.

Early in November, 1907, he contracted lues. A typical primary sore was followed by typical eruption and very sore throat. All these manifestations were observed by a very competent physician, who waited until the appearance of the eruption before instituting specific treatment. By Christmas the eruption had all disappeared. At the time the patient contracted lues he was greatly worried over depression in business. Three weeks after he had contracted the primary sore he confessed his wrong doing to his wife, and he suffered from the keenest remorse in so doing. He had suffered the greatest agony during the previous three weeks.

I saw the patient on March 10, 1908. One week ago he began to act in a silly, foolish manner. He would read the paper and start to laugh. He could not read for laughing, and this laughter was all without adequate cause. On one occasion, ten days ago, he was intoxicated. Since that time he has been at home and often, as his wife expressed it, was crazy or violent in spells of short duration. During these spells he gesticulates wildly and uses profane, obscene language. These "crazy spells" are characterized by violent, purposeless movements. The patient kicks and strikes in all directions, staggers and resists and drops to the floor if not supported. At the same time he gives utterance to loud, explosive expressions, often extremely obscene and profane. He has three or four such attacks in a day. To-day he has had two attacks.

The duration of these attacks is from five minutes to half an hour. He was out of doors to-day for a little walk with male nurse who has been in charge of him during the last four days.

Examination.—I found the patient in bed. He shook hands with me and called me "Doctor," and entered into conversation with me freely. He appears to me a good deal confused and acted in a rather mystical way. His attention would wander; his consciousness appeared clouded; he was in a dream-like state. He told me correctly the name of the street on which he resides and said the date was March 8 and the day Thursday (March 10 and Tuesday were correct). I asked him where he went in his walk to-day. He hesitated greatly and appeared to fence for reply. "I cannot say just where; I am not clear which way it was. Now you must give me time to think. Let me consider. Where did I go? I must think; I am not quite sure where we did go (after considerable pause) I can't tell you." I asked him the name of the street on which the cars travel at the corner below his house and the name of the President and Governor, and his replies were correct to these questions. He remarked, "I have had some insane fits," (long pause) "yes, insanity." The eyes wandered about the room and back to me and he appeared to become more and more confused and befogged as the examination proceeded.

I now made a brief physical examination. Examination of the chest was negative, knee-jerks were somewhat exaggerated, pain and contact senses were diminished. I next proceeded to get the patient on his feet to examine his pupils, when he gave a sudden, electric-like jerk and immediately began to call aloud in a startled frightened voice. These movements and utterances came with great suddenness and followed each other, interrupted by brief pauses, during which the patient was very quiet and limp, and would have sunk to the floor had he not been supported by the nurse and me. Gradually the movements and utterances increased in intensity and the intervals decreased, so that in a few minutes the patient was talking in a very loud, confused manner, and giving utterance to the foulest and most obscene expressions. Thinking to arouse him or to affect him by suggestion, with the nurse's assistance, I led him half way across the room and bade him stand alone. He threw himself down in a heap, struggling and kicking in most violent manner. We were compelled to hold his hands for fear of being struck ourselves. Now the utterances and movements became intermittent again. After this attack had continued thus for ten minutes, its violence began to abate a little, and by the end of half an hour the patient had resumed his usual mental condition—that in which I found him at the beginning of my visit. The extremely violent part of the attack had lasted not more than ten minutes. I now attempted to renew my examination. Pain sensation appeared everywhere diminished, but the test was not satisfactory. I asked the patient about twenty questions in arithmetic. In all but two or three instances his answers were wrong and absurdly wrong. They appear to illustrate the Vor-

beireden of Ganser. At the time I wrote down several of the specimens of the patient's answers which I am here reproducing:

$$\begin{array}{r} 3 \times 3 = 7 \\ 7 - 3 = 2 \\ 5 \times 3 = 15 \\ 11 - 4 = 2 \\ 5 - 3 = 4 \\ 7 - 4 = 9 \\ 2 + 2 = 5 \end{array}$$

These replies were given with fair degree of promptitude. Several times I corrected him; and when I did so he never insisted that he was right but looked at me in a blank, confused fashion.

A few days later the patient was sent to a sanatorium where I saw him again on April 2, about three weeks after my first visit. He recognized me and, although he appeared dazed and confused, said that I was the doctor who had called at his house. He seemed disinclined to talk. His replies were brief and he expressed no desires of any sort.

I have only recently (April 28) learned that the patient has been returned to his home and is in a quiet, docile mental state and appears nearly well.

Comments.—It would appear that in this case that the cause of the insanity was a combined psychic insult—worry over financial matters and the fact that he had contracted syphilis and that his wife had knowledge of the fact. The symptoms appeared too soon after the chancre to be attributed to syphilitic lesions of an organic character. The vigorous specific treatment would also argue against this view.

The mental symptoms, the presence of Vorbeireden and Dämmerzustand and the extremely dramatic character of the outbreaks of excitement argue for the hysterical character of the psychosis. As additional arguments may be mentioned the short course of the psychosis and the fact that it presents but little resemblance to that of any of the well-known types of insanity.

[*Note.*—An examination of this patient several weeks later, and after this paper was read, makes the diagnosis seem doubtful. The patient is now in a hospital for the insane. His mental condition is one of deep apathy or stupor. He is inattentive to the calls of nature. His pupils are small and react to light very slightly. The patient makes no utterances of any kind. He has a tendency to get into awkward attitudes. When his arms are placed in a certain position they somewhat tend to remain so in a way that is suggestive of catatonic state. But yet this sign is by no means typical in its character. The patient's present state, therefore, strongly suggests organic disease, cerebral syphilis or parietic dementia.

Yet the development and manifestations of this case are much

different from those one sees ordinarily in brain syphilis or paresis. Subsequently the patient's mental state cleared up; and he is now at home going about; and his wife thinks him as well as usual.]

CHRONIC CASES

CASE VII. (Dr. Diller.) A woman, aged 54, was seen by me for the first time on July 11, 1907.

She was married in 1875, and her first child was born in 1876. This child was drowned at the age of twenty. Another child was born in 1892, and following the birth of this child she became insane, and was in Dixmont Asylum from November, 1892, to April, 1893, when she went home. For a whole year following removal to her home she was mute, never uttering a single word. She has had about a dozen attacks of more or less similar character, since that time, but always of very short duration, some of them lasting only a few days. Besides these attacks she occasionally has had short periods of excitement, during which she has talked a good deal to herself. During the apathetic or cataleptic attacks the patient was mute, apathetic, and her limbs would remain in the position in which they were placed.

The patient had had her own way to a remarkable degree since she was a child. She had been humored by various members of the family in every possible way, and especially so since she came from the asylum, sixteen years ago. The sister informs me that no member of the family would think of contradicting the patient in any opinion she ever expressed. It was long ago found that contradiction was apt to precipitate a tantrum of some sort.

Although her husband is well thought of by the family and respected by everybody, the patient had taken a decided antipathy to him, so that he is not able to live in the same house with her. The husband is on the best of terms with the various members of the family and is consulted by them and comes to the house to see his wife occasionally. Another very curious feature of the patient's make-up is the fact that she took no interest whatever in her child born in 1892, during his infancy and childhood. But now that he has grown up a fine, large, manly boy, she feels *proud* of him. Her sister tells me she thinks the patient has no proper sort of *affection* for her boy even now.

Between the various attacks from which the patient has suffered she appears rational or nearly so. The possessor of considerable property, she gives directions as to the investment and re-investment, and her business judgment is said to be excellent.

Ever since the first attack she has been kept very quiet, living very secluded in a fine old family home here in the city, surrounded with ample grounds, garden, etc. The family feel that the patient is unable to bear any unusual excitement without becoming upset. Although her business judgment was good and

the patient, generally speaking, rational, her sister has felt that she is "never just quite right," without being able to state any more explicitly what she meant. The patient herself appears to realize that she could not stand much excitement and when company came she would voluntarily withdraw to her own room.

Ten or twelve days before my visit the patient developed one of her typical cataleptic attacks and it was thought that she would come out of it in a day or two, but to the distress of the family the attack has continued with varying mental phases up to the present time. The patient talks, scolds and is sometimes hilarious. Last night for the first time she was quite loud. The conversation to-day appears disconnected and confused, but behind it there appears considerable alertness, too. She has taken a strong antipathy to her family as she always does in her attacks. She has been sleeping very little the last two weeks.

The next day the patient was sitting up talking a great deal in low voice, in a disconnected fashion, smiling occasionally. I suggested that we play "Quaker" for five minutes, and I took out my watch to time the period of silence, holding up my finger, warning her that she must be absolutely quiet for five minutes. She did keep perfectly quiet during the next five minutes and seemed to understand something of the humor of the situation.

During the next two weeks the patient talked much in a low, muttering voice. The various sentences are usually clear in themselves, but there is no connection between them. The patient often puts her hands to her neck and mouth, giving them curious twists, making twirling worm-like movements with her fingers. By my direction she has been kept in bed most of the time. The nurses have, as a rule, controlled her very well; but she occasionally insists on getting up and for two or three days made efforts to expose herself. For a couple of weeks the talk was kept up almost continually; but on July 22, by my direction, the nurse read to her from *Vanity Fair* for about an hour, ordering her to keep quiet while she was reading.

The patient is very fond of this book, and she stopped talking and listened. She is a good French scholar and often corrected the nurse's pronunciation of the French phrases which occur in this book, and occasionally corrected her English also. Immediately upon the cessation of the reading the patient lapsed into low, muttering talk as before. It became more and more possible to attract her attention by reading and finally her attention could be attracted in this way at any time. She gradually improved and by the middle of August (six weeks after onset of the attack) she had reached her usual mental state.

She remained in this state until the latter part of February, 1908. I was called to see her March 2, 1908, and was informed that she had shown mental symptoms for ten days past. Five days ago she was very loquacious, talked all day. Next day she

was mute and cataleptic all day, assuming certain attitudes. With the beginning of the attack she had sung a good deal.

When I called I found her sitting in her bedroom, clothed in a wrapper. She greeted me with a smile and shook hands. She talked in a smiling glib manner, of which the following is a fair sample:

"Must take medicine forever—I have had enough medicine. I do not need a doctor. Just write down what you see." All this was said in a quiet voice with occasionally a quiet laugh.

The next day when I called I found the patient sitting just inside the hall door, clothed in bedroom wrapper and with the trained nurse standing beside her. I was informed that she had been there for two hours "waiting for her carriage." She talked in the same glib fashion as she did yesterday, occasionally smiling or laughing. Her eyes were half closed much of the time. She spoke much of "cutting heads off" and of "the duty of doctors." She asked to go West. She said she wanted to drive to Denver. I insisted that she go into the reception room. She resisted forcibly. I put my arm around her and forcibly carried her into the drawing room, the patient struggling and resisting during the process. But when I once got her in the drawing room all struggling ceased, and she did not attempt to go back to her former position. Seated in the drawing room she continued to talk and I put down in the note-book a number of her expressions.

"Behead them. That big Irish thing. Take a train for Denver. Strike the rebels. Exterminate them. That's right. He said it was good water. Mother will cut their heads off. Yes I like those songs. Oh! promise me. I gave up meat because I must keep myself composed. (She has refused to eat any red meat in the last four years.) Rather any roast than his own. Perfect wretch. He wants to drink butter milk. Heads off. Nasty old nerves. Drive away to Denver. The man who took charge is a union man. Death is their portion. That old china must be preserved too. The piano is dusty—dusty in every respect. Any man loitering about must be beheaded."

After a little while, with the assistance of the nurse, I carried the patient to her bedroom. She resisted and made herself stiff. Arrived in the bedroom, I put her in a rocking chair, where she rocked and smiled, but made no attempt to leave. She smiled and chatted away without showing the slightest resentment or anger.

The patient was much improved next day, and a few days later the attack was over.

Comments.—A point of peculiar interest in this case is the patient's lack of natural maternal affection for her child, which in the psychic sphere is comparable to amblyopia or analgesia in the lower sensory mechanism. This in itself is strongly sugges-

tive of hysteria. This same phenomenon was, according to her biographer, Miss Millmine, seen in Mrs. Eddy. The patient has also the same lack of feeling for her husband; and here again her case might be compared to that of Mrs. Eddy. The influence of suggestion on the patient and the absence of dementia argue for the diagnosis, as do also the original character and habits of the patient. The *Vorbeireden* of Ganser is not seen here in its typical form. But the character of the patient's mutterings and her conduct suggest an assumed foolish character, as does the *Vorbeireden* of Ganser. This case may be looked upon as one of hysteria of the mental type, whose expression is chiefly in the hysterical character and the recurrent katatonic attacks.

CASE VIII. (Dr. Diller.) The next case is that of a woman 65 years of age, who for fourteen years before her death, in January last, had been subject to recurrent attacks of hysterical delirium. This patient had been under Dr. Diller's continuous observation from March 23, 1906, until her death, on January 15, 1908, a period of nearly two years.

The patient at the time of her death had been a widow for several years, and she was childless. She had been noted in the family as having her own way to a remarkable extent—husband, sisters and all the members of the family had to give way to her. For many years she had a fondness for peculiar diet, from which she could not be persuaded to depart. She ate no meat or eggs; she had an inordinate fondness for pickles and sour tomatoes. The patient was a particularly bright woman, with keen interest in people and things about her.

Fourteen years before her death she developed an attack of insanity which lasted about two years, and during most of which time she was in a hospital for the insane. She was seen by Dr. C. K. Mills during this attack, who diagnosed it as one of hysterical insanity. She recovered entirely from this attack and from time to time had other attacks, each lasting from one to two years. At the time of her death she was for a period of about a month in the beginning of her sixth attack.

Her sister, who had been with her through all her attacks except the first one (and she had seen her in this one several times), declared that the attacks were all alike.

I saw the patient for the first time March 23, 1906. She was at that time in her own home, bedridden by reason of the deforming arthritis. The attack had begun about one year previous to the date of my first visit.

The patient was attended by two nurses, but was under the care of no physician, and she was herself controlling the situation at the house. She made frequent demands for various attentions, kept the nurse awake at night, holding that it was her duty to watch by her, and her sister was compelled to get up at three o'clock in the morning to relieve the day nurse. The pa-

tient slept in the day time, keeping awake at night for the reason—it was believed by members of the family—that the patient did not wish the nurse to sleep at night. She objected to being left alone for a single minute. She made a great many silly rhymes in a half sing song voice. Her conduct was whimsical and paradoxical. The patient was fretful, irritable and extremely unreasonable. If her demands were not satisfied she fell into crying attacks, and if they were still further refused she screamed aloud. She had her own notions about everything—taking medicine, taking food, hours for her own sleep, hours for the nurses' sleep, etc. She refused to take medicine because Dr. So-and-So had warned against it, or because of this or that theory she had read in a book. From time to time she had fleeting delusions and hallucinations of hearing. But with it all her memory was pretty well preserved, and this very fact made it all the harder for the nurses to get on with her. At times she was a great deal confused, but even then she could remember numbers, dates and figures, in a way which was remarkable. She would recall unerringly the date when the rent and interest were due and certain obligations should be paid.

By making a resolute stand at the outset, and supported by the coöperation of the family, and with the aid of the stomach tube, which was called into requisition a few times, I was able, after a few weeks, to bring something like order out of chaos in the household. The patient's objections to my rules were many and vehement. Any slip or inconsistency of nurses or doctors, real or imaginary, were sharply noted by the patient. Insomnia was a persistent symptom.

The patient required attention in various ways. Her deformed legs had to be looked after, sleep produced, diet and bowels regulated, etc. Finally a cystitis developed which caused much annoyance. But these things need not detain us.

Six months after I first saw the patient her mental condition began to improve, and this improvement continued until April, 1907, when I thought her condition normal or nearly so.

From April, 1907, to December, 1907, the patient's mind was quite clear. She attended to much business during this time and made her will. Her memory was excellent; her judgment in business matters good. She took a keen interest in people and things about her. She sent various gifts to old friends and acquaintances. She wished to know the news and gossip of the day and took a lively interest in all these things. She was fond of raillery and joking. She was considerate of her sisters, servants and all about her. A woman of some fortune, she delighted in dispensing her bounty to relieve distress or necessities of those in want. She ate well—indeed she ate too well. She readily took all medicine ordered for her. She was not fault-finding.

She remained in this restored mental state until about the middle of December, when she began to relapse. At this time her sister, who has seen the onset of several previous attacks, was quite sure the patient was going into one of "her old spells." The patient began to complain and be fault-finding. She again refused to take her medicine. Insomnia developed. She had to be urged to eat. She began to talk about her soul being lost and the dread of poverty, etc. Her joviality and good-natured banter and loquaciousness of a month ago have entirely disappeared. She now desired the nurse to be in the room constantly. Her old dread of being alone returned. She became unmindful of the comfort of the nurses and her sister. She became peevish, complaining, fretful. She complained in a vague way that "Something is wrong; things are not right in this house." Again she dreaded poverty and wished to exercise petty economies.

On the tenth of January she suffered from an acute attack of cardiac failure with uremic symptoms and expired five days later.

Comments.—It is extremely difficult to give anything like an adequate description of this case, especially in a brief account. Much could be appreciated in seeing the patient from time to time which could hardly be set down in writing. But three points stand out prominently. First, the original character of the patient. She was self-willed and notionate to a marked degree. Secondly, the chief characteristics of her attacks were peevishness, stubbornness, childishness, fault-finding. In her attacks, her desire to have her own way was marked. Thirdly, and very important, the fact that after recovering from the fifth attack of insanity the patient exhibited no residual dementia whatever.

On the negative side, her attacks of insanity were quite different from those of any well-known psychoses. We look upon the case as one of recurrent hysterical delirium.

[*Note.*—We had originally prepared as part of this paper three cases exhibiting Dämmerzustand or Vorbeireden in which the diagnosis of hysterical insanity appeared to us as doubtful. But it is perhaps unnecessary to detail these cases. Suffice it to repeat that the differential diagnosis between precocious dementia and hysterical insanity has been the problem which has presented itself in these three cases which we regard as one of great importance.]

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